Pressure Ulcers – Risk Management and Treatment
Objectives

- State reasons why individuals initiate lawsuits.
- Define strategies to reduce the risk of litigation.
- Determine appropriate treatment for the patient.
Why People Initiate Lawsuits

- Grief
- Anger
- Money
- Expectations
Plaintiff Attorney Perception of Pressure Ulcers

- Preventable
- Should heal
- Proof of bad care
- Proof of neglect
- Ischemic leg ulcers are pressure ulcers
Chain of Events

- Unrealistic expectations
- Unmet needs
- Disappointment
- Dissatisfaction
- Allegations
- Litigation
Pitfalls

- Healthcare circles the wagon
- Blame game
- Lack of documentation
- Various departments document differently
Strategies

- Assessment on admission and intervals
- Document any skin problem
- Watch the words
  - Pressure – IS IT?
  - Staging
  - Purulent
Assessment Pearls

- Source of tissue injury
  - Pressure
  - Skin Tear
  - MASD
- What devices are needed
- What does erythema indicate
- What does drainage indicate
- Is the wound infected
Anatomical Locations

Anterior View
- ear
- shoulder
- forearm
- thigh
- knee
- lower leg
- malleolus
- toes

Medial -- inner aspect
Lateral -- outer aspect

Posterior View
- occipital area
- cervical vertebrae
- scapula
- thoracic vertebrae
- elbow
- iliac crest
- sacrum
- coccyx
- trochanter
- natal cleft
- ischial tuberosity

Pressure ulcers often occur over bony prominences

Alison Schroer
NPUAP Pressure Ulcer Staging

- **Suspected Deep Tissue Injury**
- **Stage I**
- **Stage II**
- **Stage III**
- **Stage IV**
- **Unstageable**

Images of different stages of pressure ulcers are shown alongside the descriptions.
NPUAP Pressure Ulcer Staging

- Complicated
- Inter-rater reliability
- Some organizations want it changed to partial and full thickness
Suspected Deep Tissue Injury

“Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further description:
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.”

Blood-filled Blister

Dark Skin Tones
Unstageable Pressure Ulcer

“Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ‘the body’s natural (biological) cover’ and should not be removed.”

6
Kennedy Terminal Ulcer

- May occur at end-of-life
  - Usually appear on the sacrum
  - Onset is sudden
  - Pear-shaped with irregular borders
  - Characteristic colors of red, yellow, and black
CMS recognizes the Kennedy Terminal Ulcer in Long-Term Care Hospitals

Skin Failure

An event in which the skin and underlying tissue die due to hypoperfusion that occurs concurrent with severe dysfunction or failure of other organ systems

Diane Langemo
Gregory Brown
Strategies

- Check the boxes
- Fill out forms
- Be aware of the EMR
  - Same over & over
  - View other notes
- Do everything first
Strategies

- Document in notes as needed
- Document when patient refuses treatment
- Document discussions with family
- Be aware of what is said in public places
Goals

- Maintain the wound as the medical condition allows.
- Keep the patient as comfortable as possible
- Heal the wound
Delayed Healing: Medical Conditions

- Nutrition
- Hydration
- Smoking
- Edema
- Anemia
- Excessive weight
- Failure to thrive
- Infection
- Cardiovascular disease
- Diabetes mellitus
- PVD
- Renal failure
- Immunocompromised
- Medications
Causes of Non-Healing Wounds

- Health of the patient
- Co-morbidities
- Underlying wound pathology
- Complications
- Noncompliance
- Inadequate care
- Neglect/Abuse
Unavoidable Pressure Ulcers

- Federal government recognizes unavoidable pressure ulcers in the long term care setting
- Federal government does not recognize unavoidable in acute care
National Pressure Ulcer Advisory Panel (NPUAP)

- Consensus conferences Feb 2010/2014
- Not all pressure ulcers are avoidable
- Agreed on definition of unavoidable
- Adapted long term care’s definition
- Pressure Ulcer Registry
SCALE PANEL

- Skin Changes at Life’s End
- Consensus panel
- Occurs also with overwhelming illness
STOP PANEL

STOP: Shifting The Original Paradigm: Pressure Ulcer Staging
Most Stage III and Stage IV pressure ulcers do not go through the progression of, or development from, Stage I or Stage II pressure ulcers.

They begin *de novo* in the deeper tissue and present initially as Deep Tissue Injury (DTI) or as Stage III or Stage IV pressure ulcers.
In some instances, the ulcers may have had their origins as DTI (Deep Tissue Injury) as presently defined by the National Pressure Ulcer Advisory Panel.

However, in many instances they defy detection as DTI and present as “closed/covered ulcers” that present very quickly as Stage III or Stage IV ulcers, confounding the ability for early detection.
Our surveillance methods, prevention regimes, timeframes for intervention, theories about support surface performance, topical treatments, and approaches to the entire clinical course, may need to be restated.
Preventive Skin Treatments

- Incontinence care
  - Cleansers
  - Barriers
  - Catheters
- Oral care
- Skin Care
  - Cleansers
  - Moisturizers
  - Protective dressings
Wound Treatment

- Determined by wound characteristics
  - Etiology
  - Infection
  - Exudate
  - Location

- Goal of treatment
Legal Standard of Care

The care that a clinician in good standing with similar experience and education would ordinarily exercise under similar circumstances.
Attitudes

- Care
- Respect
- Dignity
- Professionalism
- Courtesy
- Kindness
The Medical Record

- IS THE PLAN OF CARE!
- Reflects patient care
- Provides snapshot of care
- Can be the best defense
What’s in the Chart

- When wound appeared
- Type
- Cause
- Description
- Treatment
- Diagnosis
- Medical history
Deposition/Trial

- Take a deep breath
- Be calm
- Tell the truth
- Plaintiff attorney’s strategy
References


References
